**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | | |
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| **In the Matter of the First Amended Accusation Against:** | ) | |
| **LAURA ANN WILLIAMS, M.D.** | ) | **Case No. 800-2015-011666** |
| **Physician's and Surgeon's Certificate No. G 76077** | ) | |
| **Respondent** | ) | |

## DECISION

**The attached Stipulated Surrender of License and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on** September 20, 2019.

**IT IS SO ORDERED** September 13, 2019.

**MEDICAL BOARD OF CALIFORNIA**

**By:** _____
**Kimberly Kirchmeyer**
**Executive Director**

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
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*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against:<br><br>**LAURA ANN WILLIAMS, M.D.**<br>**28988 Via La Rueda**<br>**Murrieta, California 92563-5730**<br><br>**Physician's and Surgeon's License No. G76077,**<br><br>Respondent. | Case No. 800-2015-011666<br><br>OAH No. 2018-080109<br><br>**STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER** |

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, and by Joseph F. McKenna III, Deputy Attorney General.

2. Laura Ann Williams, M.D., (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is: 110 West A Street, Suite 1200, San Diego, California, 92101-4959.

3. On or about March 1, 1993, the Board issued Physician's and Surgeon's License No. G76077 to Respondent. Physician's and Surgeon's License No. G76077 was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2015-011666, and expired on December 31, 2018.

4. On or about June 16, 2017, an Interim Order of Suspension (ISO) was issued by Administrative Law Judge Abraham M. Levy immediately restricting Physician's and Surgeon's License No. G76077, and prohibited Respondent from prescribing, furnishing, administering, or dispensing any controlled substances as defined under Schedules II, III, IV, and V of Health and Safety Code sections 11054 to 11058, pending the final administrative order in this matter. The ISO remains in full force and effect until the effective date of this Stipulated Settlement and Disciplinary Order.

## JURISDICTION

5. On July 7, 2017, Accusation No. 800-2015-011666 was filed against Respondent before the Board. A true and correct copy of Accusation No. 800-2015-011666 and all other statutorily required documents were properly served on Respondent on July 7, 2017. Respondent timely filed her Notice of Defense contesting the Accusation.

6. On March 28, 2018, First Amended Accusation No. 800-2015-011666 was filed before the Board, and is currently pending against Respondent. A true and correct copy of First Amended Accusation No. 800-2015-011666 and all other statutorily required documents were properly served on Respondent on March 28, 2018. A true and correct copy of First Amended Accusation No. 800-2015-011666 is attached hereto as Exhibit A and hereby incorporated by reference as if fully set forth herein.

## ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with her counsel, and fully understands the charges and allegations in First Amended Accusation No. 800-2015-011666. Respondent also has carefully read, fully discussed with her counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

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8. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in First Amended Accusation No. 800-2015-011666; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

**CULPABILITY**

10. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations in First Amended Accusation No. 800-2015-011666, and that she has thereby subjected her Physician's and Surgeon's License G76077 to disciplinary action. Respondent hereby surrenders her Physician's and Surgeon's License No. G76077 for the Board's formal acceptance.

11. Respondent further agrees that if she ever petitions for reinstatement of her Physician's and Surgeon's License No. G76077, or if an accusation and/or petition to revoke probation is filed against her before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2015-011666 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the state of California.

12. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician's and Surgeon's License No. G76077 without further notice or opportunity to be heard.

**CONTINGENCY**

13. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that she may not withdraw her agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

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## ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Order on behalf of the Board

## DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's License No. G76077, issued to Respondent Laura Ann Williams, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's License No. G76077 and the acceptance of the surrendered license by the Medical Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Medical Board's Decision and Order.

3. Respondent shall cause to be delivered to the Medical Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Medical Board's Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement of Physician's and Surgeon's License No. G76077 in the State of California, the Medical Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations, and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation

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No. 800-2015-011666 shall be deemed to be true, correct, and admitted by Respondent when the Medical Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2015-011666 shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

## ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Robert W. Frank, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's License No. G76077. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Disciplinary Order of the Medical Board of California.

DATED: 9-3-19

LAURA ANN WILLIAMS, M.D.
*Respondent*

I have read and fully discussed with Respondent Laura Ann Williams, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 9-3-19

ROBERT W. FRANK, ESQ.
*Attorney for Respondent*

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## ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: September 4, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**First Amended Accusation No. 800-2015-011666**

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*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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| In the Matter of the First Amended Accusation Against:<br><br>**Laura Ann Williams, M.D.**<br>**28988 Via La Rueda**<br>**Murrieta, California 92563-5730**<br><br>**Physician's and Surgeon's License No. G76077,**<br><br>Respondent. | Case No. 800-2015-011666<br><br>OAH No. 2017-050978<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about March 1, 1993, the Medical Board issued Physician's and Surgeon's Certificate No. G76077 to Laura Ann Williams, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on December 31, 2018, unless renewed.

3. On or about June 16, 2017, an Interim Order of Suspension was issued immediately restricting Physician's and Surgeon's Certificate No. G76077, prohibiting Respondent from prescribing, furnishing, administering, or dispensing any controlled substances as defined under Schedules II, III, IV, and V of Health and Safety Code sections 11054 to 11058. The Order will remain in effect, pending a full determination whether Respondent violated the Medical Practice Act or upon further order by the Medical Board.

## JURISDICTION

4. This First Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(d) Incompetence.

" ..."

7. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

8. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

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"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, 'addict' means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

9. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

"...

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"...

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"..."

10. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct

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within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

11. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

12. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of

diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

13. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

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## FIRST CAUSE FOR DISCIPLINE

**(Gross Negligence)**

14. Respondent has subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in her care and treatment of patients A.M., B.Y., R.A., I.A., B.B., R.H., and M.W., as more particularly alleged hereinafter:

15. **Patient A.M.**

(a) On or about March 24, 2008, Respondent had her first visit with patient A.M., a then-49-year-old female.[1] At this first visit, patient A.M. saw Respondent to establish care and Respondent charted her health history which included chronic shoulder pain. Patient A.M. suffered chronic pain from avascular necrosis of the shoulder and she had undergone numerous surgical procedures to both shoulders. On or about December 6, 2014, patient A.M. was found dead in the bedroom of her apartment by her landlord. The coroner ruled patient A.M.'s death as an accidental overdose caused by the combined effects of Oxycodone[2] and Hydrocodone.[3] Patient A.M.'s death came only three (3) days after she was last seen for a patient visit by Respondent, on or about December 3, 2014.

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[1] Conduct occurring more than seven (7) years from the filing date of this First Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[2] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The Drug Enforcement Administration (DEA) has identified opioids, such as Oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.) For example, Percocet and Endocet are brand names for the drug combination of oxycodone-acetaminophen, which is commonly prescribed under the generic name of Oxycodone/APAP.

[3] Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as Hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.) For example, Vicodin, Lortab, and Norco are brand names for the drug combination of hydrocodone bitartrate-acetaminophen, which is commonly prescribed under the generic name of Hydrocodone/APAP.

(b) During the period of January 1, 2011, to December 31, 2011, Respondent charted twenty-one (21) visits with patient A.M. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 3, January 4, January 13, January 27, February 3, February 17, February 22, March 23, April 20, May 18, June 1, June 23, June 30, July 28, August 30, August 31, September 21, September 28, October 26, November 23, and December 20, 2011. The chart notes for these visits include massive amounts of prescriptions for opioids and benzodiazepines.[4] Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of two (2) different benzodiazepines and opioids to patient A.M. In addition, the chart notes for these visits show that Respondent over-dosed patient A.M. at toxic levels with acetaminophen-containing medications.[5] In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient A.M. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient A.M.

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[4] Benzodiazepines (e.g., Lorazepam, Temazepam, and Diazepam) are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and are a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, they are used for the management of anxiety disorders or for the short-term relief of anxiety. Concomitant use of benzodiazepines with opioids may result in profound sedation, respiratory depression, coma, and/or death. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 55.) For example, Valium is a brand name for Diazepam.

[5] For adults, acetaminophen has a maximum daily dose ceiling of 4,000 mg (4.0 gm) per twenty-four (24) hour day. In acute use, taking more than 4 gm in eight (8) hours can result in severe liver damage or fatal overdose. Taking more than 7,500 mg (7.5 gm) in a day can cause severe liver damage or fatal overdose.

(c) A chart note dated January 3, 2011, documented that patient A.M. was "requesting all meds refilled – just filled on 12-20-10." However, there is no other information documented in the chart note to explain patient A.M.'s request for an early refill of her controlled medications. Patient A.M. was seen the following day, on January 4, 2011, and it was noted in the chart note for this visit that she had been in a "car accident last week." However, there is no other information documented in the chart note to corroborate the alleged car accident or explaining the request for an early refill of her controlled medications. The medications were re-filled at this visit.

(d) On or about April 20, 2011, Respondent had patient A.M. sign a "Medication Contract" which listed prescribed controlled pain medications by name, dose, direction, and quantity, as well as contained rules and conditions regarding patient A.M.'s use of the medications that she was required to follow. Specifically, Patient A.M. was required to request all refills through Respondent and that if she received refills by any other doctor(s) it would result in discharge from Respondent's practice. However, a three (3) month Controlled Substance Utilization Review and Evaluation System[6] (CURES) report contained in patient A.M.'s medical record documented that she had filled multiple prescriptions for controlled medications from other doctors after signing the "Medication Contract." In fact, on or about May 18, 2011, Respondent's office received a telephone call from an unknown pharmacy regarding patient A.M. receiving narcotics from more

[6] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

than one provider. The only other documentation about this incident was recorded in a chart note dated on or about June 1, 2011, which indicated only "issue of meds from other providers." There is no other clear documentation in the medical record of any warning being given against refilling controlled prescriptions from multiple providers. Instead of discharging patient A.M. for clear violations of the "Medication Contract," Respondent continued refilling her massive prescriptions for controlled pain medications.

(e) In a chart note dated September 28, 2011, Respondent documented under diagnostic assessment that patient A.M. had "narcotic dependence."

(f) Based upon a review of the chart notes for the visits in 2011, there is no documentation that any lab work ever confirmed that patient A.M. had been taking the controlled pain medications that Respondent was routinely prescribing to her on a monthly basis.

(g) During the period of January 1, 2012, to December 31, 2012, Respondent charted thirteen (13) visits with patient A.M. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 17, February 7, March 6, April 3, April 17, May 3, May 31, June 26, July 24, August 21, September 15, November 20, and December 20, 2012. Again, the chart notes for these visits include massive amounts of prescriptions for opioids and benzodiazepines. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of two (2) different benzodiazepines and opioids to patient A.M. In addition, the chart notes for these visits show that Respondent continued over-dosing patient A.M. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled

medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient A.M. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient A.M.

(h) A chart note dated January 17, 2012, documented a discussion with patient A.M. about the "dangers of continuing so much acetaminophen." The note further documented that patient A.M. was "unwilling to change" the controlled medications that were being prescribed to her. After this visit, Respondent, with full knowledge of the toxic amount of acetaminophen being prescribed to patient A.M., continued refilling her massive prescriptions of Oxycodone/APAP and Hydrocodone/APAP.

(i) A chart note dated February 7, 2012, documented that patient A.M. was "getting 2 months' worth of opiates every 4 weeks – needs clarification." The note further documented that "[patient A.M.] seems not to understand the 'double Rx'ing' but she is smarter than that." After this visit, Respondent continued refilling patient A.M.'s massive prescriptions for controlled pain medications.

(j) Chart notes from April and May of 2012 recorded concern over patient A.M.'s acetaminophen levels and usage, but the chart notes failed to document what if any modifications to acetaminophen dosages were discussed with the patient. Respondent continued refilling patient A.M.'s massive prescriptions for acetaminophen-containing pain medications.

(k) Based upon a review of the chart notes for the visits in 2012, there is no documentation that any lab work ever confirmed that patient A.M. had been taking the controlled pain medications that Respondent was routinely prescribing to her on a monthly basis.

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(l) During the period of January 1, 2013, to December 31, 2013, Respondent charted twenty-two (22) visits with patient A.M. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 9, January 21, January 24, January 30, February 25, March 13, March 28, April 15, May 1, May 9, May 15, May 22, June 5, June 26, July 23, July 30, August 8, September 4, September 25, October 22, November 12, and December 3, 2013. Again, the chart notes for these visits include massive amounts of prescriptions for opioids and benzodiazepines. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of two (2) different benzodiazepines and opioids to patient A.M. In addition, the chart notes for these visits show that Respondent continued over-dosing patient A.M. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient A.M. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient A.M.

(m) On or about July 23, 2013, Respondent required patient A.M. to sign a "Narcotic Contract," in part due to patient A.M. being caught using as many as six (6) different pharmacies to obtain controlled substances. The contract limited patient A.M. to filling prescriptions at two (2) pharmacies designated under the contract.

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(n) A chart note dated August 8, 2013, documented that a "long discussion about meds use + abuse" was held with patient A.M., and that she needed a "pain management consult ASAP." After this visit, Respondent continued refilling patient A.M.'s massive prescriptions for controlled pain medications.

(o) In a chart note dated September 4, 2013, Respondent documented for the second time in the record that patient A.M. had "narcotic dependence;" however, Respondent, with full knowledge of patient A.M.'s clear and repeated aberrant drug behaviors, granted an early refill of her addictive pain medications.

(p) Based upon a review of the chart notes for the visits in 2013, there is no documentation that any lab work ever confirmed that patient A.M. had been taking the controlled pain medications that Respondent was routinely prescribing to her on a monthly basis.

(q) During the period of January 1, 2014, to December 31, 2014, Respondent charted eleven (11) visits with patient A.M. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 28, February 18, March 11, April 2, April 23, May 9, June 5, June 25, August 27, September 24, and December 3, 2014. Again, the chart notes for these visits include massive amounts of prescriptions for opioids and benzodiazepines. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of two (2) different benzodiazepines and opioids to patient A.M. In addition, the chart notes for these visits show that Respondent continued over-dosing patient A.M. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear

rationale for continuing to prescribe massive amounts of controlled medications to patient A.M. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient A.M.

(r) A chart note dated March 11, 2014, documented that patient A.M. was "very upset" due to her father dying in the hospital and that she had requested "extra" medication. Although Respondent documented in this chart note that she had discussed her concerns over current medication usage with patient A.M., she issued two (2) prescriptions to patient A.M. that same day, which were prescriptions for Hydrocodone/APAP (325 MG-10 MG) (#120) and Oxycodone/APAP (325 MG-10 MG) (#120). Significantly, Respondent failed to document any discussion with patient A.M. about what had happened to prescriptions that she had filled only three (3) weeks earlier, on February 18, 2014, for Hydrocodone/APAP (325 MG-10 MG) (#240) and Oxycodone/APAP (325 MG-10 MG) (#240). In a span of only twenty-one (21) days, patient A.M. filled prescriptions issued by Respondent totaling seven hundred twenty (#720) tablets of controlled pain medication.

(s) A chart note dated June 25, 2014, documented that patient A.M. was told to "alternate" between her prescriptions for Norco and Percocet. In a handwritten note dated that same day, it was documented that patient A.M. had been "running out of her medication [to] quick" and that "Percocet & Norco in total of both medication she has 240 pill so each are 120 pills ... [patient A.M.] was told to not take both of them at the same time anymore!" Notwithstanding these documented concerns over patient A.M.'s use of her controlled prescriptions, Respondent continued refilling her massive prescriptions for addictive pain medications.

(t) A chart note dated September 24, 2014, documented the recent deaths of patient A.M.'s sister and father, that Respondent had diagnosed her with acute anxiety, and that she needed assistance for obtaining a psychiatric consultation.

(u) The last chart note in patient A.M.'s medical record, dated December 3, 2014, documented her final visit with Respondent just three (3) days before her over-dose death. Respondent failed to document any further information or discussion in the note about whether a psychiatric consultation for patient A.M. had ever occurred. Instead, Respondent only documented "anxiety" in the note for this visit. Respondent, with full knowledge of the numerous "red flags" showing patient A.M. had been repeatedly abusing and misusing her addictive pain medications for several years and the recent diagnosis of acute anxiety due to the recent deaths of her father and sister, still issued two (2) large prescriptions to patient A.M. at this visit. Respondent issued one prescription for Hydrocodone/APAP (325 MG-10 MG) (#240) and two (2) prescriptions for Oxycodone HCL (325 MG-10 MG) (#120). Significantly, only two (2) weeks earlier, on November 19, 2014, patient A.M. had filled multiple prescriptions issued by Respondent including, a prescription for Hydrocodone/APAP (325 MG-10 MG) (#120) and a prescription for Oxycodone HCL (325 MG-10 MG) (#120). Remarkably, Respondent issued prescriptions to patient A.M. totaling seven hundred twenty (#720) tablets of controlled pain medication in a span of only two (2) weeks.

(v) Based upon a review of the chart notes for the visits in 2014, there is no documentation that any lab work ever confirmed that patient A.M. had been taking the controlled pain medications that Respondent was routinely prescribing to her on a monthly basis.

(w) According to the CURES report for patient A.M. and her medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient A.M. an average of approximately twenty-one and one half (21.5) tablets of opioid medication, per day, for more than three (3) years. In addition, Respondent prescribed to patient A.M. an average of approximately eight (8) grams of acetaminophen, per day, for more than three (3) years.

| Patient Name | Date Filled[7] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 08-30-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 08-31-2011 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 09-16-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 09-28-2011 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 10-05-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 10-10-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 36 | III |
| A.M. | 10-12-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 64 | III |
| A.M. | 10-26-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 10-26-2011 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 04-03-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 04-03-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 05-31-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 06-06-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 06-27-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 06-27-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 07-06-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 07-24-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 08-02-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 112 | III |
| A.M. | 08-06-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 128 | III |
| A.M. | 08-23-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 08-23-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 09-25-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 10-04-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 10-25-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 10-25-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 11-20-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 11-20-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 12-20-2012 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |

[7] Patient A.M. filled her prescriptions on or about these dates.

| Patient Name | Date Filled[7] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 12-20-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 120 | III |
| A.M. | 01-01-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 01-09-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 01-09-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 01-24-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 90 | III |
| A.M. | 01-30-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 01-30-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 02-21-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 50 | III |
| A.M. | 03-13-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 03-13-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 03-28-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 120 | III |
| A.M. | 03-28-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 03-28-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 04-05-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| A.M. | 04-15-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 04-15-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 05-01-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 202 | III |
| A.M. | 05-01-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 05-10-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 180 | III |
| A.M. | 05-15-2013 | Oxycodone/APAP | TAB | 325 MG-5 MG | 180 | II |
| A.M. | 05-18-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 158 | III |
| A.M. | 05-22-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 180 | III |
| A.M. | 05-23-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 180 | II |
| A.M. | 06-05-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 360 | III |
| A.M. | 06-05-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 06-20-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 64 | III |
| A.M. | 06-25-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 180 | III |
| A.M. | 06-26-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 200 | II |
| A.M. | 06-26-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 160 | II |

| Patient Name | Date Filled[7] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 07-06-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 180 | III |
| A.M. | 07-16-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 180 | III |
| A.M. | 07-18-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 180 | III |
| A.M. | 07-19-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 120 | III |
| A.M. | 07-19-2013 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 60 | III |
| A.M. | 07-23-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 200 | II |
| A.M. | 07-30-2013 | Hydrocodone/APAP | TAB | 7.5 MG-200 MG | 120 | III |
| A.M. | 08-02-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 08-08-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 360 | III |
| A.M. | 08-21-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 180 | III |
| A.M. | 09-04-2013 | Oxycodone HCL | TAB | 325 MG-5 MG | 240 | II |
| A.M. | 09-04-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 09-25-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 09-25-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 10-22-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 10-22-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 11-12-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 11-12-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 11-12-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 11-12-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 12-05-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 12-05-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 12-05-2013 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 01-03-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 360 | II |
| A.M. | 01-09-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 01-10-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 01-28-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 01-28-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 02-18-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |

| Patient Name | Date Filled[7] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 02-18-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 03-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 03-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 03-11-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 03-11-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 04-01-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 30 | III |
| A.M. | 04-02-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| A.M. | 04-06-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 180 | III |
| A.M. | 04-11-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 60 | II |
| A.M. | 04-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 04-11-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 04-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 60 | III |
| A.M. | 04-23-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 04-23-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 05-09-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 05-09-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 05-22-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 180 | III |
| A.M. | 06-03-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 06-04-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 60 | III |
| A.M. | 06-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 06-25-2014 | Oxycodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 06-27-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 06-27-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 07-10-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 07-19-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 07-19-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 08-07-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 08-09-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| A.M. | 08-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |

| Patient Name | Date Filled[7] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 08-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 08-27-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 180 | II |
| A.M. | 09-02-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 09-10-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 180 | II |
| A.M. | 09-24-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| A.M. | 09-24-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 10-24-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 250 | II |
| A.M. | 10-24-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | II[8] |
| A.M. | 11-19-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 11-19-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 12-03-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| A.M. | 12-04-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 120 | II |
| A.M. | 12-04-2014 | Oxycodone HCL | TAB | 325 MG-10 MG | 120 | II |

(x) According to the CURES report for patient A.M. and her medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient A.M. an average of nearly four (4) caplets and/or tablets of benzodiazepines, per day, for more than three (3) years.

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[8] On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. HCPs are pharmaceutical drugs containing specified doses of hydrocodone in combination with other drugs in specified amounts. There are several hundred brand name and generic hydrocodone products marketed in the United States with the most frequently prescribed combination being hydrocodone and acetaminophen (e.g., Vicodin, Norco, and Lortab.). Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. After considering the analysis and rescheduling recommendation of Department of Health and Human Services and reviewing available data, the DEA found that HCPs meet the statutory definition of a schedule II controlled substance. Various drug abuse indicators for HCPs indicate that HCPs are widely diverted and abused at rates largely similar to that of oxycodone products (schedule II). The data indicate that HCPs have an abuse potential similar to schedule II opioid analgesics such as oxycodone and their abuse is associated with severe psychological or physical dependence. Abuse of HCPs is also associated with large numbers of individuals being admitted to addiction treatment centers. Individuals are taking these drugs in sufficient quantities to create a hazard to their health, and abuse of HCPs is associated with large numbers of deaths.

| Patient Name | Date Filled[9] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 09-15-2011 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 10-06-2011 | Diazepam | TAB | 10 MG | 120 | IV |
| A.M. | 10-10-2011 | Temazepam | CAP | 30 MG | 3 | IV |
| A.M. | 10-12-2011 | Temazepam | CAP | 30 MG | 12 | IV |
| A.M. | 10-26-2011 | Temazepam | CAP | 30 MG | 90 | IV |
| A.M. | 12-05-2011 | Diazepam | TAB | 10 MG | 120 | IV |
| A.M. | 04-12-2012 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 05-29-2012 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 07-03-2012 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 07-24-2012 | Diazepam | TAB | 10 MG | 60 | IV |
| A.M. | 11-20-2012 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 11-20-2012 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 12-20-2012 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 12-20-2012 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 01-10-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 02-11-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 02-22-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 03-12-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 04-15-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 04-29-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 05-06-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 06-03-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 06-06-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 07-01-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 07-10-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 07-29-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 08-09-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 08-21-2013 | Temazepam | CAP | 30 MG | 30 | IV |

[9] Patient A.M. filled her prescriptions on or about these dates.

| Patient Name | Date Filled[9] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 09-11-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 09-26-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 10-09-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 10-23-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 11-08-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 11-14-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 12-05-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 12-09-2013 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 12-31-2013 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 01-09-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 01-10-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 01-27-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 02-01-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 02-18-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 02-18-2014 | Lorazepam | TAB | 2 MG | 60 | IV |
| A.M. | 03-01-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 03-05-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 03-20-2014 | Lorazepam | TAB | 2 MG | 60 | IV |
| A.M. | 03-27-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 03-27-2014 | Diazepam | TAB | 10 MG | 60 | IV |
| A.M. | 03-28-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 04-22-2014 | Diazepam | TAB | 10 MG | 60 | IV |
| A.M. | 04-24-2014 | Temazepam | CAP | 30 MG | 60 | IV |
| A.M. | 04-24-2014 | Temazepam | CAP | 30 MG | 120 | IV |
| A.M. | 05-09-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 05-29-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 05-29-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 05-29-2014 | Diazepam | TAB | 10 MG | 60 | IV |
| A.M. | 06-11-2014 | Diazepam | TAB | 10 MG | 90 | IV |

| Patient Name | Date Filled[9] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| A.M. | 06-25-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 06-25-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 06-27-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 07-22-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 07-23-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 07-24-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 08-22-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 08-25-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 09-10-2014 | Temazepam | CAP | 30 MG | 90 | IV |
| A.M. | 09-16-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 09-16-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 09-23-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 09-26-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 10-21-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 10-23-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 11-20-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| A.M. | 11-21-2014 | Temazepam | CAP | 30 MG | 30 | IV |
| A.M. | 11-21-2014 | Temazepam | CAP | 30 MG | 30 | IV |

(y) On October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient A.M. During the subject interview, Respondent acknowledged that she had documented patient A.M. as "narcotic dependent" as early as 2011. However, in defense of her prescribing of sufficient quantities of controlled pain medications to massively overdose patient A.M., Respondent stated that she had counseled patient A.M. not to overuse her medications and to "alternate the medicine." Respondent then admitted that even though she was prescribing more controlled pain medications than was safe for patient A.M. to take, according to Respondent, it was patient A.M.'s responsibility not to over-

dose the medication that she had been prescribed, as she explained to the Medical Board:

> "Yeah ... doesn't mean she's supposed to take it ... But she's not supposed to take it. She has a free will. ... If you have a gun, are you gonna take it and shoot yourself? ... How about alcohol? You're gonna go buy that fifth of alcohol. Right? Are you gonna drink it or not? It's your choice."

Remarkably, Respondent, with full knowledge of the multiple "red flags" of patient A.M.'s repeated aberrant drug behaviors, made the above statement and did so even after acknowledging that patient A.M. had documented narcotic dependence.

16. Respondent committed gross negligence in her care and treatment of patient A.M. including, but not limited to, the following:

(a) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient A.M.;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered benzodiazepines to patient A.M.;

(c) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient A.M.;

(d) Respondent failed to obtain and document informed consent from patient A.M. prior to beginning treatment with opioids;

(e) Respondent failed to obtain and document informed consent from patient A.M. prior to beginning long-term treatment with benzodiazepines;

(f) Respondent failed to obtain and document informed consent from patient A.M. prior to prescribing concomitant use of opioids and benzodiazepines;

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(g) Respondent improperly issued prescriptions for controlled medications that exceeded a thirty (30) day supply;

(h) Respondent documented that on April 2, 2014, Percocet was discontinued as a medication, but then Respondent continued to prescribe the medication without documentation of the rationale for such continuation;

(i) Respondent failed to provide appropriate treatment to patient A.M. in that she, among other things, repeatedly prescribed inherently addictive controlled medications such as opiates and benzodiazepines to patient A.M. over an extended period of time, while failing to respond to objective signs of aberrant drug behavior that involved addiction, misuse, abuse, and/or diversion of the controlled medications; and

(j) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient A.M. The records are frequently incomplete, lack adequate detail, and/or failed to provide Respondent's clinical rationale for the amounts of controlled medications that she had prescribed to patient A.M. The records failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids. The records also failed to document Respondent's clinical judgment behind prescribing a medication combination of two (2) different benzodiazepines and opioids to patient A.M. at the same time; or her clinical judgment behind prescribing benzodiazepines to patient A.M. for long-term use; or her clinical judgment behind prescribing acetaminophen-containing medications at the dosage levels that she had prescribed to patient A.M. The records also failed to adequately document prescription information involving the timing and issuance of controlled medications prescribed to patient A.M. The records also failed to document bases for any

diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

17. **Patient B.Y.**

(a) On or about September 2, 2008, Respondent had her first visit with patient B.Y., a then-42-year-old male.[10] Respondent documented that Patient B.Y. had suffered from lower back pain for six (6) years. At the time of his first visit with Respondent, patient B.Y. was taking an unspecified quantity of Norco of an unknown strength.

(b) During the period of January 1, 2011, to December 31, 2011, Respondent charted sixteen (16) visits with patient B.Y. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 4, January 25, March 11, March 30, April 19, May 19, June 16, July 12, July 29, August 18, August 23, September 20, October 4, October 21, November 22, and December 13, 2011. The chart notes for these visits include massive amounts of prescriptions for opioids and Soma.[11] Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the

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[10] Conduct occurring more than seven (7) years from the filing date of this First Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[11] Soma is a brand name for Carisoprodol, which is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, published comment on Carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

concomitant use of Soma and two (2) hydrocodone/acetaminophen drugs to patient B.Y. In addition, the chart notes for these visits show that Respondent over-dosed patient B.Y. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient B.Y. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient B.Y.

(c) A chart note dated April 19, 2011, documented that patient B.Y. had been sent home from work due to increased pain. However, nothing further is documented in the note about the change in pain or further discussion regarding other modalities to treat the increased pain reported by patient B.Y.

(d) A chart note dated June 16, 2011, documented that patient B.Y. had questions for Respondent and the notation "overwork + chronic pain" was included in the note. However, nothing further is documented in the note about the change in pain or further discussion regarding other modalities to treat the increased pain reported by patient B.Y.

(e) A chart note dated October 4, 2011, documented that patient B.Y. was seen for a medication refill only and included the notation "need more pain meds – will be travelling to San Onofre." Respondent then issued two (2) prescriptions for a four (4) month supply of Hydrocodone/APAP (325 MG-10 MG) (#240), Oxycodone/APAP (325 MG-10 MG) (#120), and Carisoprodol (350 MG) (#90). Significantly, later that same month, Respondent approved additional prescriptions for controlled pain medication as "early refills" because patient B.Y. was going to be "out of town." The early refill prescriptions issued by Respondent included,

Oxycodone/APAP (325 MG-10 MG) (#240), Hydrocodone/APAP (325 MG-10 MG) (#240), and Hydrocodone/APAP (750 MG-7.5 MG) (#150). In total, patient B.Y. filled eleven (11) prescriptions totaling one thousand eighty (#1080) tablets of controlled pain medications in October 2011.

(f) A chart note dated December 13, 2011, included the notation that patient B.Y. "needs refill on medication." Notwithstanding the massive amount of controlled pain medications filled by patient B.Y. in October 2011, Respondent refilled all of his controlled prescriptions in November 2011 and December 2011.

(g) Based upon a review of the chart notes for the visits in 2011, there is no documentation that any lab work ever confirmed that patient B.Y. had been taking the controlled pain medications that Respondent was routinely prescribing to him on a monthly basis.

(h) During the period of January 1, 2012, to December 31, 2012, Respondent charted twenty-six (26) visits with patient B.Y. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 3, January 23, February 6, February 23, March 1, March 8, March 28, April 16, May 15, May 22, May 31, June 14, June 28, July 13, July 25, August 6, August 9, August 14, September 10, September 25, October 11, October 25, November 19, and December 6, December 18, and December 27, 2012. Again, the chart notes for these visits include massive amounts of prescriptions for opioids and Soma. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of Soma and two (2) hydrocodone/acetaminophen drugs to patient B.Y. In addition, the chart notes for these visits show that Respondent continued over-dosing patient B.Y. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding

physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient B.Y. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient B.Y.

(i) A chart note dated January 23, 2012, documented patient B.Y.'s representation that a pharmacy had shorted him seventy (70) tablets of his Soma prescription, and that the pharmacy had dispensed only twenty (20) tablets to him. The pharmacy was contacted and its staff confirmed that the "count was accurate" and that ninety (90) tablets of Soma had in fact been dispensed under the prescription. No further discussion is documented in the note over whether patient B.Y. had been counseled about possible diversion or misuse of the prescription.

(j) A chart note dated May 31, 2012, documented the lab results of a recent drug toxicology screen for patient B.Y. and that the results were discussed with him. Significantly, the lab results were entirely negative for all of the controlled prescriptions issued by Respondent to patient B.Y. Without any further explanation, Respondent's handwritten notation on the lab report declared "only taking his meds [no] illegal substances." All of patient B.Y.'s controlled prescriptions were refilled on this visit, and without any documentation of a discussion with him about the negative lab results, why prescribed medications were not detected in his sample, and/or whether he had been counseled about possible diversion or misuse of his controlled prescriptions.

(k) Based upon a review of the chart notes for the visits in 2012, there is no documentation that any lab work ever confirmed that patient B.Y. had been taking the controlled pain medications that Respondent was routinely prescribing to him on a monthly basis.

(l) During the period of January 1, 2013, to December 31, 2013, Respondent charted twenty-seven (27) visits with patient B.Y. As best as can be discerned from the handwritten chart notes, the visits took place on or about January 10, February 5, February 18, February 22, March 4, March 11, March 25, April 3, April 18, April 23, April 30, May 9, May 20, June 6, June 11, June 26, July 10, July 24, August 5, August 8, August 27, September 10, September 25, October 10, October 22, November 12, and December 4, 2013. Again, the chart notes for these visits include massive amounts of prescriptions for opioids and Soma. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of Soma and two (2) hydrocodone/acetaminophen drugs to patient B.Y. In addition, the chart notes for these visits show that Respondent continued over-dosing patient B.Y. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient B.Y. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient B.Y.

(m) A chart note dated March 25, 2013, documented that patient B.Y. had reported pain levels as "10/10." The location and cause of the pain were briefly documented in the note; however, no discussion was documented regarding other modalities to treat the increased pain reported by patient B.Y. Instead, patient B.Y.'s controlled prescriptions were simply refilled.

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(n) A chart note dated April 23, 2013, recorded a notation indicating "discussed long term disability application – seek counsel with union." Again, however, no discussion was documented regarding other modalities to treat the increased pain reported by patient B.Y. Instead, patient B.Y.'s controlled prescriptions were simply refilled.

(o) On or about July 10, 2013, an early refill prescription for Oxycodone HCL (30MG) (#120) was approved for patient B.Y. and a notation in his chart note for a same day visit indicated "pain contract." However, the note failed to document the reason(s) for approval of an early refill for patient B.Y.

(p) A chart note dated July 24, 2013, included a notation indicating "next visit pain contract." However, a pain contract is not signed by patient B.Y. until on or about February 5, 2014.

(q) On or about September 25, 2013, an early refill prescription for Oxycodone HCL (30MG) (#120) was approved for patient B.Y., despite the contradictory stories he had given to explain a recent injury and the inconsistent reasons why he was out of pain medication and in need of an early refill. An early refill was again given with no further documentation of any discussion about what had happened to the large amounts of Oxycodone HCL and Hydrocodone/APAP recently filled by patient B.Y.

(r) Based upon a review of the chart notes for the visits in 2013, there is no documentation that any lab work ever confirmed that patient B.Y. had been taking the controlled pain medications that Respondent was routinely prescribing to him on a monthly basis.

(s) During the period of January 1, 2014, to September 30, 2014, Respondent charted seven (7) visits with patient B.Y. As best as can be discerned from handwritten chart notes, the visits took place on or about February 5, April 2, May 5, June 18, August 20, September 10, and September 17, 2014. Again, the chart notes for these visits include massive amounts of prescriptions for opioids

and Soma. And, consistent with the previous year's care and treatment for this patient, Respondent failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of Soma and two (2) hydrocodone/acetaminophen drugs to patient B.Y. In addition, the chart notes for these visits show that Respondent continued over-dosing patient B.Y. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient B.Y. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient B.Y.

(t) On or about February 5, 2014, more than five (5) years after beginning treatment with addictive pain medications, patient B.Y. signed a "Patient Contract for Using Opioid Pain Medication in Chronic Pain." Important stipulations of this contract included, that patient B.Y. agreed his opioid medication would be prescribed by only one (1) doctor and that he would fill his prescriptions at only one (1) pharmacy. After signing the contract, Patient B.Y. violated this stipulation and filled his controlled prescriptions at eight (8) different pharmacies. Despite clear violations of the contract, there was no documentation in the record that patient B.Y. was cautioned against the use of multiple pharmacies.

(u) Based upon a review of the chart notes for the visits in 2014, there is no documentation that any lab work ever confirmed that patient B.Y. had been taking the controlled pain medications that Respondent was routinely prescribing to him on a monthly basis.

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(v) According to the CURES report for patient B.Y. and his medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient B.Y. an average of approximately fourteen and one half (14.5) tablets of opioid medication, per day, for more than four (4) years. In addition, from in or around August 2011, to in or around August 2014, Respondent prescribed to patient B.Y. an average of approximately four and one quarter (4.25) grams of acetaminophen, per day.

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 07-16-2010 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 10-18-2010 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 11-23-2010 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 12-20-2010 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 12-22-2010 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 01-12-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 01-19-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 03-06-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 03-07-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 03-24-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 05-25-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 06-02-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 07-08-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 12 | III |
| B.Y. | 07-12-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 07-29-2011 | Oxycodone/APAP | TAB | 325/10 MG | 240 | II |
| B.Y. | 08-09-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 08-09-2011 | Hydrocodone/APAP | TAB | 750/7.4 MG | 30 | III |
| B.Y. | 08-16-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 08-19-2011 | Oxycodone/APAP | TAB | 325/10 MG | 240 | II |
| B.Y. | 08-21-2011 | Oxycodone/APAP | TAB | 325/10 MG | 240 | II |

[12] Patient B.Y. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 09-06-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 09-06-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 09-20-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 09-20-2011 | Oxycodone/APAP | TAB | 325/10 MG | 240 | II |
| B.Y. | 10-03-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 10-05-2011 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 10-05-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 10-06-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 10-17-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 10-21-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 10-24-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 10-24-2011 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 10-24-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 10-28-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 10-28-2011 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 11-07-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 11-07-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 11-25-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 11-28-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 11-28-2011 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 11-28-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 12-08-2011 | Hydrocodone/APAP | TAB | 750/7.5 MG | 50 | III |
| B.Y. | 12-14-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 12-29-2011 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 01-04-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 01-04-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 01-19-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 01-19-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 01-23-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 01-25-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 02-14-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 02-21-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 03-08-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 03-08-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 05-07-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 05-24-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 05-24-2012 | Oxycodone/APAP | TAB | 325/10 MG | 180 | II |
| B.Y. | 06-19-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 06-20-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 06-28-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 07-04-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 07-06-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 90 | III |
| B.Y. | 08-06-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 72 | III |
| B.Y. | 08-07-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 72 | III |
| B.Y. | 08-10-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 36 | III |
| B.Y. | 08-14-2012 | Oxycodone/APAP | TAB | 325/10 MG | 120 | II |
| B.Y. | 08-14-2012 | Hydrocodone/APAP | TAB | 750/7.5 MG | 120 | III |
| B.Y. | 09-25-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 10-11-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 11-19-2012 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 11-19-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 12-06-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 12-06-2012 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 12-18-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 12-18-2012 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 12-27-2012 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 12-27-2012 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 01-10-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 01-10-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 01-24-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 01-30-2013 | Oxycodone HCL | TAB | 15 MG | 120 | II |
| B.Y. | 01-30-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 02-18-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 02-22-2013 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| B.Y. | 03-07-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 03-25-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 80 | III |
| B.Y. | 04-04-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 04-04-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 04-18-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 04-29-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 04-30-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 05-05-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 60 | III |
| B.Y. | 05-09-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 360 | III |
| B.Y. | 05-20-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 05-24-2013 | Oxycodone/APAP | TAB | 325/10 MG | 90 | II |
| B.Y. | 05-27-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 06-03-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 360 | III |
| B.Y. | 06-03-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 360 | III |
| B.Y. | 06-17-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 06-26-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 06-26-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 07-08-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 07-11-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 07-18-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 07-24-2013 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| B.Y. | 08-02-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 120 | III |
| B.Y. | 08-08-2013 | Oxycodone HCL | TAB | 30 MG | 180 | II |

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 08-16-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 08-26-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 08-28-2013 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| B.Y. | 09-04-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 90 | III |
| B.Y. | 09-20-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 09-20-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 09-25-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 09-25-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 126 | III |
| B.Y. | 10-10-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 72 | III |
| B.Y. | 10-22-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 10-22-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 11-07-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 72 | III |
| B.Y. | 11-12-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 11-12-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 12-04-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 12-07-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 12-14-2013 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 12-14-2013 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 01-01-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 01-04-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 01-10-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 01-11-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 01-27-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 02-05-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 02-05-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 02-19-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 02-28-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 03-12-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 03-12-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |

| Patient Name | Date Filled[12] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 04-01-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 04-05-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 04-10-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 04-24-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 05-06-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 05-15-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 05-27-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 06-18-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 06-18-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 06-23-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 07-18-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 07-18-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 07-25-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 240 | III |
| B.Y. | 08-06-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 08-20-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 08-20-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |
| B.Y. | 09-10-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 09-17-2014 | Hydrocodone/APAP | TAB | 325/10 MG | 180 | III |
| B.Y. | 09-19-2014 | Oxycodone HCL | TAB | 30 MG | 120 | II |

(w) According to the CURES report for patient B.Y. and his medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient B.Y. an average of approximately five and one half (5.5) tablets of Soma, per day, for more than four (4) years.

| Patient Name | Date Filled[13] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 07-30-2010 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-20-2011 | Soma | TAB | 350 MG | 60 | IV |
| B.Y. | 04-20-2011 | Soma | TAB | 350 MG | 180 | IV |

[13] Patient B.Y. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[13] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 06-02-2011 | Soma | TAB | 350 MG | 60 | IV |
| B.Y. | 07-08-2011 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 07-08-2011 | Soma | TAB | 350 MG | 16 | IV |
| B.Y. | 08-09-2011 | Soma | TAB | 350 MG | 50 | IV |
| B.Y. | 08-09-2011 | Soma | TAB | 350 MG | 30 | IV |
| B.Y. | 08-23-2011 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 09-21-2011 | Soma | TAB | 350 MG | 30 | IV |
| B.Y. | 10-05-2011 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 10-24-2011 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 11-28-2011 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-14-2011 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-04-2012 | Soma | TAB | 350 MG | 30 | IV |
| B.Y. | 01-19-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 03-26-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 05-07-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 06-19-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 06-28-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y | 08-06-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 08-14-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 09-25-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 10-11-2012 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 11-19-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-06-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-18-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-27-2012 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-03-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-10-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-21-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-30-2013 | Soma | TAB | 350 MG | 120 | IV |

| Patient Name | Date Filled[13] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 02-18-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 03-14-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 03-25-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-04-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 04-16-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-29-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 05-09-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 05-20-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 06-03-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 06-12-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 06-26-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 07-08-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 07-18-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 08-02-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 08-16-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 08-26-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 09-20-2013 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 09-25-2013 | Soma | TAB | 350 MG | 63 | IV |
| B.Y. | 10-10-2013 | Soma | TAB | 350 MG | 36 | IV |
| B.Y. | 10-22-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 11-07-2013 | Soma | TAB | 350 MG | 24 | IV |
| B.Y. | 11-12-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-04-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 12-26-2013 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-01-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-10-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-04-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 01-27-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 02-05-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 02-19-2014 | Soma | TAB | 350 MG | 120 | IV |

| Patient Name | Date Filled[13] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.Y. | 02-28-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 03-12-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-01-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-10-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 04-24-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 05-06-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 05-15-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 05-28-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 06-01-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 06-23-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 07-11-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 07-18-2014 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 07-25-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 08-06-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 08-14-2014 | Soma | TAB | 350 MG | 90 | IV |
| B.Y. | 08-20-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 09-09-2014 | Soma | TAB | 350 MG | 60 | IV |
| B.Y. | 09-19-2014 | Soma | TAB | 350 MG | 120 | IV |
| B.Y. | 09-26-2014 | Soma | TAB | 350 MG | 120 | IV |

(x) On October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient B.Y. During the subject interview, Respondent defended her prescribing of Soma for more than five (5) years to patient B.Y. by stating, "[Soma's] not addicting according to the PDR." In reality, the Physician's Desk Reference (PDR) identifies Soma (carisoprodol) as a schedule IV drug that has potential for "psychological dependence, drug abuse, [and] drug misuse;" that "criminal diversion have been reported with prolonged use of carisoprodol and with meprobamate, one of the metabolites of carisoprodol;" and that "to reduce abuse potential, limit the duration of therapy to a maximum of 3 weeks." During

her subject interview, Respondent was also asked about numerous "red flags" indicating aberrant drug behaviors by patient B.Y. including, he used fifteen (15) separate pharmacies to fill prescriptions from 2012 to 2014 and the 2012 drug toxicology screen that was "negative" for all of his prescribed medications. Respondent told the Medical Board that she was not alarmed by the patient's apparent pharmacy shopping or the negative results of his drug screen.

18. Respondent committed gross negligence in her care and treatment of patient B.Y. including, but not limited to, the following:

(a) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient B.Y.;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered Soma to patient B.Y.;

(c) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient B.Y.;

(d) Respondent failed to obtain and document informed consent from patient B.Y. prior to beginning treatment with opioids;

(e) Respondent failed to obtain and document informed consent from patient B.Y. prior to beginning long-term treatment with Soma;

(f) Respondent failed to obtain and document informed consent from patient B.Y. prior to prescribing concomitant use of opioids and Soma;

(g) Respondent improperly issued prescriptions for controlled substances that exceeded a thirty (30) day supply;

(h) Respondent failed to provide appropriate treatment to patient B.Y. in that she, among other things, repeatedly prescribed inherently addictive controlled medications such as opiates and Soma to patient B.Y. over an extended period of time, while failing to respond to objective signs of aberrant drug behavior that involved addiction, misuse, abuse, and/or diversion of the controlled medications; and

(i) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient B.Y. The records are frequently incomplete, lack adequate detail, and/or failed to provide Respondent's clinical rationale for the amounts of controlled medications that she had prescribed to patient B.Y. The records failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids. The records also failed to document Respondent's clinical judgment behind prescribing a medication combination of opioids and Soma to patient B.Y. at the same time; or her clinical judgment behind prescribing Soma to patient B.Y. for more than three (3) weeks; or her clinical judgment behind prescribing acetaminophen-containing medications at the dosage levels that she had prescribed to patient B.Y. The records also failed to adequately document prescription information involving the timing and issuance of controlled medications prescribed to patient B.Y. The records also failed to document bases for any diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

19. **Patient R.A.**

(a) On or about January 26, 2012, Respondent's physician assistant (whom she supervised) saw patient R.A., a then-53-year-old male, to establish care with Respondent's practice. Patient R.A.'s several medical conditions included, Chronic Obstructive Pulmonary Disease (COPD), stroke, tobacco smoking, Hepatitis C, cirrhosis, rheumatoid arthritis, and chronic pain. Patient R.A. also had a documented history of mental health problems, heavy alcohol abuse and intravenous (IV) drug abuse.

(b) During the period of January 1, 2012, to May 31, 2014, Respondent charted nineteen (19) visits with patient R.A. As best as can be discerned from the

handwritten chart notes, the visits took place on or about January 26, March 6, April 3, May 1, May 29, 2012; January 3, February 14, March 18, May 2, June 18, July 10, August 8, September 10, October 9, November 6, December 3, 2013; February 4, April 1, and May 14, 2014. The chart notes for these visits include massive amounts of prescriptions for opioids, benzodiazepines, and morphine.[14] There was no clinical rationale documented to justify such a prescribing pattern for patient R.A. Respondent, with knowledge of patient R.A.'s history of alcohol abuse and IV drug use, failed to adequately document her clinical judgment behind prescribing highly addictive medications to a patient with a history of substance abuse. Respondent, with knowledge of patient R.A.'s diagnosed COPD, failed to document her clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time she prescribed the concomitant use of three (3) different opioids and benzodiazepines to patient R.A. In addition, the chart notes for these visits show that Respondent over-dosed patient R.A. at toxic levels with acetaminophen-containing medications. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe massive amounts of controlled medications to patient R.A. Significantly, based upon a review of the chart notes for these visits, Respondent failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient R.A.

(c) A chart note dated January 23, 2012, documented that patient R.A. was "establishing care" with Respondent's practice. On patient R.A.'s health history

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[14] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

form, he denied use of "drugs" and "other." No other information is documented in the note for this visit about any history involving prior alcohol abuse, substance abuse and/or IV drug use. On or about that same date, Respondent sent requests for records to patient R.A.'s previous medical providers, which were later received and document the patient's substance abuse history.

(d) A chart note dated May 29, 2012, indicated patient R.A. was seen that day by Respondent for an office visit. Respondent documented that patient R.A. was "confused" and that he needed to have a mental status work-up. On or about that same day, Respondent sent patient R.A. to Sharp Grossmont Hospital to be evaluated because of concern that he may be encephalopathic with altered mental status. More than seven (7) months will pass before patient R.A. had his next documented visit with Respondent.

(e) A chart note dated January 3, 2013, documented that patient R.A. received a three (3) month supply of morphine with the notation "but needs to be adherent." The note also indicated that patient R.A. had reported increased pain and had also requested a magnetic resonance imaging (MRI). Significantly, there is no documentation about the results of patient R.A.'s evaluation at Sharp Grossmont Hospital from seven (7) months earlier. There is no documentation of any discussion with patient R.A. about his mental status and/or pain management since his last charted visit. There was only scant documentation regarding his current health status and no physical examination was performed. Despite the significant gap of time since Respondent last saw patient R.A., and with no documentation about how he had been treating his pain over the previous seven (7) months, Respondent issued massive prescriptions to patient R.A. for the following controlled medications: Morphine (100 MG) (#540), Morphine (30 MG) (#540), Hydrocodone/APAP (325 MG-10 MG) (#540), Hydrocodone/APAP (325 MG-10 MG) (#540), and Diazepam (10 MG) (#540). Lastly, Respondent does not document any discussion with patient R.A. about any history involving prior

alcohol abuse, substance abuse and/or IV drug use before issuing massive amounts of addictive pain medications.

(f) On or about January 24, 2013, patient R.A. was seen at Sharp Grossmont Hospital for fever and shortness of breath and COPD exacerbation. The following was documented in the hospital's report: "Former IV drug abuser," "Chronic pain with severe drug seeking behavior," "Hepatitis C secondary to IV drug abuse," "History of IV drug abuse," "Cirrhosis secondary to alcohol abuse and Hepatitis C," "Alcohol abuse," and "Severe drug-seeking behavior." A copy of the hospital's report was sent to Respondent, and her initials appear on the hospital's discharge summary.

(g) A chart note dated February 14, 2013, documented only a scant notation about patient R.A.'s visit only three (3) weeks earlier to Sharp Grossmont Hospital. Significantly, Respondent, despite the "red flags" raised by the hospital's report, continued refilling massive prescriptions of addictive pain medications to patient R.A. without any apparent follow up or documentation of his alcohol and IV drug abuse history.

(h) On or about May 28, 2013, Respondent received a facsimile from United Health Care's Narcotic Drug Utilization Program identifying prescriptions of non-standard, high daily doses of Morphine, Hydrocodone/APAP, and Diazepam issued to patient R.A., a member under the United Health Care plan. United Health Care requested that Respondent evaluate patient R.A.'s medication profile because his dosages "significantly exceeded the FDA-labeled maximum daily doses" of these controlled medications.

(i) A chart note dated June 18, 2013, documented the refilling of patient R.A.'s controlled prescription medication. Also recorded in the note were notations indicating "review med +plan as well as drug addiction ... referral needed to manage this patient" and "advised of risk of narcotic usage and drug interaction." However, aside from these scant references, there is no

documentation that patient R.A. had reviewed and/or signed a pain management contract explaining risks of using opioid pain medication for long term treatment of chronic pain on or before this visit.

(j) A chart note dated July 10, 2013, documented that a one (1) hour review took place to discuss with patient R.A. his medications and use of "multiple pharmacies." Also documented in the note were his "overuse of narcotics + valium," that pain management was needed as soon as possible, and that labs were needed at the next visit. Finally, it was also documented that patient R.A. was "having difficulty managing prn meds due to memory deficit ... hepatic encephalopathy." However, Respondent still continued to prescribe a dangerous combination, quantity, and dose variation of controlled medications, along with complex instructions for daily use of long-acting opioids, to a patient whom she believed had memory problems and a history of mental health issues.

(k) A chart note dated November 6, 2013, documented that patient R.A. was not able to report his dosing of his medications, that he was "narcotic dependent," and that he had been "*Strongly Encouraged* to not overuse meds or they will be [discontinued]." Despite continuing "red flags" being exhibited by patient R.A., Respondent refilled all of his addictive pain medications at this visit.

(l) On or about February 4, 2014, a pain management contract was signed by patient R.A. and Respondent.

(m) The final chart note for patient R.A., dated May 14, 2014, documented referrals to orthopedics, rheumatology, and pain management. A notation indicated "No more refills between now and 6 weeks." On the same date of patient R.A.'s final charted visit, he was discharged from Respondent's practice. In an undated letter signed by Respondent, the reasons cited for patient R.A.'s discharge were non-compliance with pain medication regimen, non-compliance with pain management referrals, and allegedly being seen outside of Respondent's medical office by a member of her staff while he was walking without the

assistance of his walker. However, there was no documentation in the chart note that patient R.A. was being discharged from Respondent's practice or referred elsewhere for his primary care. Significantly, there is no documentation in the record of Respondent's plan to safely taper patient R.A.'s opioid or benzodiazepine medication, and no documentation in the record that Respondent made any effort to help patient R.A. find another primary care physician.

(n) Respondent, despite discharging patient R.A. from her practice in May 2014, continued refilling his prescriptions for controlled pain medication in December 2014, and again in January and February 2015. However, the are no chart notes in patient R.A.'s medical record to show that Respondent ever physically evaluated him before issuing these controlled prescriptions.

(o) Respondent diagnosed patient R.A. with hepatic encephalopathy,[15] however, she failed to initially document an adequate health history; failed to perform and document an adequate physical examination; failed to conduct diagnostic studies to obtain biochemical evidence of hepatic insufficiency and/or exclude other pathologies; and failed to perform therapeutic interventions into any of his multiple medical complaints to exclude other pathologies.[16] Because Respondent only treated patient R.A. for pain, she prescribed him

[15] Hepatic encephalopathy is a metabolic derangement in which decrease in hepatic synthetic and metabolic capacity causes buildup of toxins and toxic metabolites in the body, causing the brain to have difficulty with normal function. It is marked by progressively more severe central nervous system decline, marked first by fatigue and progressing to coma. It is marked by decreases in intellectual function, at first subtle, and gradually progressing to delirium. It is associated with neuromuscular abnormalities that begin as tremor, progress to include asterixis, slurred speech, ataxia, and finally coma. It is graded in stages, zero to four, with zero marked by sleep disturbance alone and four marked by coma. Disorientation begins with stage 2, while frank confusion begins in late stage 3.

[16] In a patient with suspected hepatic encephalopathy, other common causes of delirium must be excluded. In patient R.A.'s case, intoxicated delirium due to the combined use of morphine, Norco, and Valium would have to be excluded. Hepatic encephalopathy is a clinical diagnosis that is confirmed by the presence of elevated serum ammonia level, abnormal liver enzymes, elevated bilirubin, decreased albumin and increased clotting time.

massive amounts of controlled pain medications which had the potential to cause delirium for the patient. Respondent attributed patient R.A.'s hepatic encephalopathy to end-stage liver disease, however, there was no evidence of end-stage liver disease from laboratory evaluations and/or imaging studies. In fact, there are multiple metabolic panels in patient R.A.'s medical record and none of them showed any evidence of end stage liver disease.

(p) On October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient R.A. During the subject interview, Respondent stated that she was not aware that patient R.A. had a history of IV drug abuse and that he had been diagnosed with "severe narcotic-seeking behavior." In defense of her massive over-prescribing of addictive pain medications to patient R.A., Respondent stated in her subject interview that she did not think patient R.A. took all of the medications that she had prescribed him every month:

> "No. I don't think – he may or may not be … using it. Just because he has it – he was pretty forgetful with his encephalopathy, and his wife is the one that dispensed the medicine to him. Not him. … She kept it, 'cause he would get confused."

Remarkably, Respondent was fully aware of patient R.A.'s difficulty with understanding, let alone following, variable dose instructions for Morphine ER, Morphine IR, Norco, and Valium, and yet she continued prescribing massive amounts of these controlled medications to him.

(q) According to the CURES report for patient R.A. and his medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient R.A. an average of approximately eight (8) tablets of Morphine, per day, for nearly three (3) years.

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| Patient Name | Date Filled[17] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 04-03-2012 | Morphine Sulfate | TAB | 15 MG | 120 | II |
| R.A. | 04-03-2012 | Morphine Sulfate | TER[18] | 100 MG | 120 | II |
| R.A. | 01-03-2013 | Morphine Sulfate | TER | 100 MG | 540 | II |
| R.A. | 01-08-2013 | Morphine Sulfate | TAB | 30 MG | 540 | II |
| R.A. | 05-03-2013 | Morphine Sulfate | TER | 100 MG | 540 | II |
| R.A. | 05-07-2013 | Morphine Sulfate | TAB | 30 MG | 540 | II |
| R.A. | 06-18-2013 | Morphine Sulfate | TER | 100 MG | 90 | II |
| R.A. | 06-18-2013 | Morphine Sulfate | TAB | 30 MG | 540 | II |
| R.A. | 07-10-2013 | Morphine Sulfate | TER | 100 MG | 160 | II |
| R.A. | 07-24-2013 | Morphine Sulfate | TAB | 30 MG | 160 | II |
| R.A. | 08-08-2013 | Morphine Sulfate | TER | 60 MG | 120 | II |
| R.A. | 08-23-2013 | Morphine Sulfate | TAB | 30 MG | 360 | II |
| R.A. | 09-10-2013 | Morphine Sulfate | TER | 100 MG | 180 | II |
| R.A. | 09-20-2013 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 10-09-2013 | Morphine Sulfate | TER | 100 MG | 60 | II |
| R.A. | 10-18-2013 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 11-06-2013 | Morphine Sulfate | TER | 100 MG | 60 | II |
| R.A. | 11-10-2013 | Morphine Sulfate | TAB | 30 MG | 360 | II |
| R.A. | 12-03-2013 | Morphine Sulfate | TAB | 30 MG | 240 | II |
| R.A. | 12-03-2013 | Morphine Sulfate | TER | 100 MG | 60 | II |
| R.A. | 01-03-2014 | Morphine Sulfate | TAB | 30 MG | 240 | II |
| R.A. | 01-06-2014 | Morphine Sulfate | TER | 100 MG | 60 | II |
| R.A. | 02-04-2014 | Morphine Sulfate | TAB | 30 MG | 280 | II |
| R.A. | 02-05-2014 | Morphine Sulfate | TER | 100 MG | 70 | II |
| R.A. | 03-04-2014 | Morphine Sulfate | TER | 100 MG | 70 | II |
| R.A. | 03-04-2014 | Morphine Sulfate | TAB | 30 MG | 280 | II |
| R.A. | 04-01-2014 | Morphine Sulfate | TAB | 30 MG | 280 | II |

[17] Patient R.A. filled his prescriptions on or about these dates.

[18] Dosage form is a tablet/extended release.

| Patient Name | Date Filled[17] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 04-02-2014 | Morphine Sulfate | TER | 100 MG | 90 | II |
| R.A. | 04-30-2014 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 05-15-2014 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 05-16-2014 | Morphine Sulfate | TER | 100 MG | 90 | II |
| R.A. | 12-02-2014 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 12-02-2014 | Morphine Sulfate | TER | 100 MG | 180 | II |
| R.A. | 12-31-2014 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 01-02-2015 | Morphine Sulfate | TER | 100 MG | 180 | II |
| R.A. | 01-14-2015 | Morphine Sulfate | TAB | 30 MG | 100 | II |
| R.A. | 01-30-2015 | Morphine Sulfate | TAB | 30 MG | 180 | II |
| R.A. | 02-05-2015 | Morphine Sulfate | TER | 100 MG | 126 | II |

(r) According to the CURES report for patient R.A. and his medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient R.A. an average of approximately seven and one half (7.5) tablets of opioid medication, per day, for more than two and a half (2.5) years. In addition, Respondent over-prescribed acetaminophen to patient R.A. at many different intervals including, but not limited to, from on or about May 7, 2013, to on or about July 21, 2013, when Respondent prescribed an average of approximately four and three quarters (4.75) grams of acetaminophen, per day.

| Patient Name | Date Filled[19] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 04-11-2012 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 180 | III |
| R.A. | 05-04-2012 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 180 | III |
| R.A. | 01-03-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 540 | III |
| R.A. | 05-07-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 540 | III |
| R.A. | 06-18-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 540 | III |

[19] Patient R.A. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[19] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 07-22-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 160 | III |
| R.A. | 08-22-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 09-10-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 160 | III |
| R.A. | 10-09-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 11-06-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 12-03-2013 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 01-06-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 02-04-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 03-04-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 04-01-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 04-30-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 05-22-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| R.A. | 12-02-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | II |

(s) According to the CURES report for patient R.A. and his medication list in the medical record, which prescriptions have been summarized in the table below, Respondent prescribed to patient R.A. an average of approximately four (4) tablets of benzodiazepines, per day, for nearly (3) years.

| Patient Name | Date Filled[20] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 04-06-2012 | Diazepam | TAB | 5 MG | 180 | IV |
| R.A. | 05-05-2012 | Diazepam | TAB | 5 MG | 180 | IV |
| R.A. | 05-07-2012 | Diazepam | TAB | 5 MG | 180 | IV |
| R.A. | 05-29-2012 | Diazepam | TAB | 5 MG | 180 | IV |
| R.A. | 01-03-2013 | Diazepam | TAB | 10 MG | 540 | IV |
| R.A. | 05-10-2013 | Diazepam | TAB | 10 MG | 540 | IV |
| R.A. | 06-18-2013 | Diazepam | TAB | 10 MG | 540 | IV |
| R.A. | 07-22-2013 | Diazepam | TAB | 10 MG | 160 | IV |

[20] Patient R.A. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[20] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.A. | 08-30-2013 | Diazepam | TAB | 10 MG | 180 | IV |
| R.A. | 10-09-2013 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 11-06-2013 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 12-03-2013 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 01-03-2014 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 02-04-2014 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 03-04-2014 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 04-01-2014 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 04-30-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| R.A. | 05-23-2014 | Diazepam | TAB | 10 MG | 120 | IV |
| R.A. | 12-02-2014 | Diazepam | TAB | 10 MG | 90 | IV |
| R.A. | 01-01-2015 | Diazepam | TAB | 10 MG | 90 | IV |
| R.A. | 01-22-2015 | Diazepam | TAB | 10 MG | 90 | IV |
| R.A. | 02-14-2015 | Diazepam | TAB | 10 MG | 90 | IV |

20. Respondent committed gross negligence in her care and treatment of patient R.A. including, but not limited to, the following:

(a) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered morphine to patient R.A.;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient R.A.;

(c) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered benzodiazepines to patient R.A.;

(d) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient R.A.;

(e) Respondent failed to adequately review medical records from patient R.A.'s previous medical providers before beginning and/or maintaining him on long-term use of addictive pain medications;

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(f) Respondent failed to obtain and document informed consent from patient R.A. prior to beginning treatment with morphine, opioids, and/or benzodiazepines;

(g) Respondent improperly issued prescriptions for controlled substances that exceeded a thirty (30) day supply;

(h) Respondent failed to provide appropriate treatment to patient R.A. in that she, among other things, repeatedly prescribed inherently addictive controlled medications such as morphine, opiates and benzodiazepines to patient R.A. over an extended period of time, while failing to respond to objective signs of aberrant drug behavior that involved addiction, misuse, abuse, and/or diversion of the controlled medications;

(i) Respondent, after reviewing the January 24, 2013, report from Sharp Grossmont Hospital that had raised "red flags" about patient R.A.'s "severe drug seeking-behavior," failed to document these serious concerns nor any discussion regarding them with patient R.A., and/or document a thorough evaluation of her then-existing pharmacological treatment regimen of this patient;

(j) Respondent, after documenting on or about November 6, 2013, that patient R.A. had "narcotic dependence," failed to discontinue, taper, and/or alter her prescriptions for controlled pain medications after that date;

(k) Respondent, after abruptly discharging patient R.A. from her practice, failed to provide patient with enough time to secure another medical provider; and, given the serious and complicated regimen of controlled medications that patient R.A. was taking, Respondent's failure to discuss tapering of medications with him placed his health and safety at serious and immediate risk;

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(l) Respondent, after discharging patient R.A. from her practice on or about May 14, 2014, resumed prescribing controlled pain medications to him over a three (3) month period, from in or around December 2014, to February 2015, without charting a single visit, and no other documentation exists to show that Respondent and/or another licensed medical provider saw him before refilling these controlled prescriptions;

(m) Respondent diagnosed patient R.A. with "hepatic encephalopathy" without first evaluating, performing, and/or documenting a broad differential diagnosis to exclude other potential pathologies that may have been causing his delirium including, but not limited to, she failed to conduct and/or document diagnostic studies to obtain biochemical evidence of hepatic insufficiency to exclude other pathologies; failed to perform and/or document therapeutic interventions into any of his multiple medical complaints to exclude other pathologies; and failed to document any evaluation whether the massive amount of controlled medications prescribed to patient R.A. were the root cause of delirium and/or whether tapering of medications would alter her diagnosis; and

(n) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient R.A. The records are frequently incomplete, lack adequate detail, and/or failed to provide Respondent's clinical rationale for the amounts of controlled medications that she had prescribed to patient R.A. The records failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids. The records also failed to document Respondent's clinical judgment behind prescribing varying levels of dosage of long-acting opioids to patient R.A.; or her clinical judgment behind prescribing acetaminophen-containing medications at the dosage levels that she had prescribed to patient R.A. The records

also failed to adequately document prescription information involving the timing and issuance of controlled medications prescribed to patient R.A. The records also failed to document bases for any diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

21. **Patient I.A.**

(a) On or about March 15, 2010, patient I.A., a then-41-year-old male, was first seen at Respondent's practice by referral for physical therapy.[21] The chart note for this visit only listed his current medications, but history, physical, assessment, and plan are otherwise left blank in the note. A chart note dated May 25, 2010, documented patient I.A.'s complaint was that he had been feeling lower abdominal pain all the way in his back for over one (1) year. At an office visit later that year, on or about December 14, 2010, Respondent diagnosed patient I.A. with "IBS, Barrett's Esophagus, Diverticulitis."

(b) During the period of January 1, 2011, to December 31, 2014, Respondent charted thirty (30) visits with patient I.A. As best as can be discerned from the handwritten chart notes, the visits took place on or about February 22, March 11, March 17, March 31, May 26, July 14, August 11, September 26, November 29, 2011; January 16, March 14, March 21, April 12, May 24, May 31, June 28, September 4, October 25, December 20, 2012; February 6, March 28, April 30, June 26, August 28, 2013; January 21, August 13, August 18, September 12, October 22, and December 11, 2014. The chart notes for these visits include excessive amounts of prescriptions for opioids and acetaminophen. There was no clinical rationale documented to justify such a prescribing pattern for patient I.A.

[21] Conduct occurring more than seven (7) years from the filing date of this First Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

Respondent failed to document a detailed history of patient I.A.'s pain; failed to document a detailed physical examination; failed to document how and to what extent the pain interfered with his function; and failed to document a recognized indication for the use of opioids. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe controlled medications to patient I.A. for his chronic pain. Respondent failed to adequately chart prescription information for patient I.A.'s controlled medications including type, quantity, when they were prescribed and how long were they expected to last. Significantly, based upon a review of the chart notes for these visits, Respondent also failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient I.A.

(c) A chart note dated July 14, 2011, documented a history of patient I.A.'s right flank pain for the first time. At his next visit, on or about August 11, 2011, the assessment noted "chronic diverticulitis vs appendicitis" and a pending "MRI." The physical examination is blank, except for a check mark indicating that an abdominal examination was abnormal. The abnormality was not described in the note. Respondent refilled patient I.A.'s controlled prescriptions at this visit.

(d) A chart note dated September 26, 2011, documented that patient I.A.'s abdominal pain had not been relieved at his currently prescribed dosage levels, and that he had increased the prescribed daily amount of controlled pain medication on his own. Respondent refilled patient I.A.'s controlled prescriptions at this visit, but failed to document any warnings and/or discussion about deviating from the prescribed dosage levels of his controlled medication.

(e) On or about July 10, 2013, approximately two and a half (2.5) years after beginning treatment with controlled pain medications issued by Respondent,

patient I.A. signed a "Narcotic Contract" prepared by Respondent's clinic, Alpine Creek Family Medicine.

(f) A chart note dated December 11, 2014, documented that patient I.A. had intractable chronic abdominal pain unrelieved by Tramadol.[22] However, Respondent failed to document her rationale for the use of Tramadol; failed to document informed consent; and failed to document what instructions were given to patient I.A. and exactly what quantity the prescription was started at.

(g) Based upon a review of the chart notes for these visits, there is no documentation that any lab work ever confirmed that patient I.A. had been taking the controlled pain medications that Respondent was routinely prescribing to him on a monthly basis.

(h) On October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient I.A. During the subject interview, Respondent admitted that she was aware that 4.7 gm of acetaminophen were being dispensed to patient I.A. in the latter half of 2011. According to Respondent, however, patient I.A. had been instructed to only take it "prn" or on an "as needed" basis. Therefore, Respondent was not concerned that this patient would over-dose his medication because, as she told the Medical Board, "half the time [patients] don't even fill the script."

(i) According to the CURES report for patient I.A. and his medication list in the medical record, prescriptions for his opioid medication have been summarized in the table below. In addition, Respondent over-prescribed

[22] Tramadol is a synthetic opioid medication that binds to opioid *mu* receptors in the central nervous system (CNS) and weakly inhibits norepinephrine and serotonin reuptake. It is a DEA Schedule IV drug. It carries black box warnings regarding its abuse potential, respiratory depression, and the dangers of accidental ingestion, in which even a single accidental dose can sometimes be fatal. It carries a black box warning that concomitant use with benzodiazepines, alcohol, or other CNS depressants may result in profound sedation, respiratory depression, coma, and death. The black box warnings state "limit to minimum required dosage and duration; monitor patients for signs and symptoms of respiratory depression and sedation."

acetaminophen to patient I.A. at many different intervals including, but not limited to, from on or about July 22, 2012, to on or about September 4, 2012, when Respondent prescribed an average of approximately four and one half (4.5) grams of acetaminophen, per day.

| Patient Name | Date Filled[23] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| I.A. | 1-10-2011 | Hydrocodone/APAP | TAB | 500 MG-5 MG | 90 | III |
| I.A. | 01-31-2011 | Hydrocodone/APAP | TAB | 500 MG-5 MG | 90 | III |
| I.A. | 02-23-2011 | Hydrocodone/APAP | TAB | 500 MG-5 MG | 90 | III |
| I.A. | 02-25-2011 | Hydrocodone/APAP | TAB | 500 MG-5 MG | 90 | III |
| I.A. | 04-04-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 240 | III |
| I.A. | 05-26-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 240 | III |
| I.A. | 06-21-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 07-14-2011 | Hydrocodone/APAP | TAB | 500 MG-5 MG | 120 | III |
| I.A. | 08-11-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 08-12-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 09-02-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 09-27-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 10-17-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 10-19-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 11-16-2011 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 240 | III |
| I.A. | 11-29-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 12-21-2011 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 240 | III |
| I.A. | 02-14-2012 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 120 | III |
| I.A. | 04-17-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 240 | III |
| I.A. | 05-31-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 90 | III |
| I.A. | 06-25-2012 | Hydrocodone/APAP | TAB | 500 MG- 7.5 MG | 30 | III |
| I.A. | 06-29-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 90 | III |
| I.A. | 07-22-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 90 | III |

[23] Patient I.A. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[23] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| I.A. | 08-04-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 180 | III |
| I.A. | 09-05-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 10-02-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 11-25-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 12-21-2012 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 01-11-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 02-07-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 03-04-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 03-30-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 05-01-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 05-30-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 06-26-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 07-26-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 08-29-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 09-25-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 60 | III |
| I.A. | 10-02-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 150 | III |
| I.A. | 10-28-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 30 | III |
| I.A. | 11-13-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 12-09-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 60 | III |
| I.A. | 12-24-2013 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 01-21-2014 | Hydrocodone/APAP | TAB | 750 MG-7.5 MG | 120 | III |
| I.A. | 02-25-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 120 | III |
| I.A. | 03-23-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 60 | III |
| I.A. | 04-10-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 05-22-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 06-23-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 08-01-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 08-21-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 08-29-2014 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 180 | III |
| I.A. | 01-19-2015 | Hydrocodone/APAP | TAB | 325 MG-7.5 MG | 120 | II |

22. Respondent committed gross negligence in her care and treatment of patient I.A. including, but not limited to, the following:

(a) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient I.A.;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient I.A.;

(c) Respondent failed to obtain and document informed consent from patient I.A. prior to beginning treatment with opioids and/or Tramadol;

(d) Respondent failed to document her rationale for the use of Tramadol, what instructions were given to patient I.A., and exactly what quantity the prescription was started at;

(e) Respondent improperly managed patient I.A.'s abdominal pain by prescribing the long-term use of opioids after the diagnoses of appendicitis and diverticulitis had been made;

(f) Respondent improperly issued prescriptions for controlled substances that exceeded a thirty (30) day supply; and

(g) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient I.A. The records are frequently incomplete, lack adequate detail, and/or failed to provide Respondent's clinical rationale for the amounts and dosages of controlled medications that she had prescribed to patient I.A. The records failed to document her clinical judgment behind prescribing acetaminophen-containing medications at the dosage levels that she had prescribed to patient I.A. The records also failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids. The records also failed to adequately document prescription information involving the timing, quantity, and issuance of controlled medications prescribed to patient I.A. The records also failed

to document bases for any diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

23. **Patient B.B.**

(a) On or about April 13, 2010, patient B.B., a then-71-year-old female, was first seen by Respondent at her office.[24] The chart note for this visit only documented a scant history with the notation "diabetes f/u." An examination was documented for normal heart, abdomen, and neurological. No assessment and no plan was documented.

(b) During the period of January 1, 2011, to February 28, 2014, Respondent charted sixteen (16) visits with patient B.B. As best as can be discerned from the handwritten chart notes, the visits took place on or about August 25, September 1, September 7, September 15, September 21, September 28, October 5, October 14, December 13, 2011; January 4, February 21, October 25, October 31, 2012; February 7, June 12, 2013; and February 11, 2014. The chart notes for these visits include massive amounts of prescriptions for opioids and acetaminophen, and there was no clinical rationale documented to justify such a prescribing pattern for patient B.B. Respondent failed to document a detailed history of patient B.B.'s pain; failed to document a detailed physical examination; failed to document how and to what extent the pain interfered with her function; and failed to adequately document a recognized indication for the use of opioids. In general, the chart notes are frequently either incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe controlled medications to

[24] Conduct occurring more than seven (7) years from the filing date of this First Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

patient B.B. for her chronic pain. Significantly, based upon a review of the chart notes for these visits, Respondent also failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient B.B.

(c) A chart note dated September 15, 2011, documented that patient B.B. had recently been admitted for a massive upper gastrointestinal bleeding event, but no history nor physical examination was documented in the note.

(d) A chart note dated October 25, 2012, does not document a gastrointestinal history nor a review of symptoms. A scant physical examination is charted, but does not include an abdominal examination. The assessment noted osteoarthritis. An injection of Toradol[25] was given to patient B.B. at the visit, but the dosage was not recorded in the note. There is no documentation of informed consent nor discussion about the risks of administering Toradol to this patient.

(e) Between the charted visits on October 31, 2012, and on February 11, 2014, a period of approximately fifteen (15) months, patient B.B. had no documented visits with a licensed medical provider. Significantly, however, twelve (12) controlled prescriptions for Hydrocodone/APAP (varying strengths) were issued to patient B.B. during that same period of time, with a combined total quantity of one thousand six hundred sixty (#1660) tablets. And again, after the last charted visit in February 2014, Respondent issued another ten (10) controlled prescriptions for Hydrocodone/APAP (325 MG-10 MG) to patient B.B., with a combined total quantity of two thousand one hundred sixty (#2160) tablets, without any documentation in the record.

(f) Between on or about April 27, 2013, and on or about July 9, 2013, Respondent prescribed doses of Hydrocodone/APAP to patient B.B. sufficient for

[25] Toradol is a nonsteroidal anti-inflammatory drug used short-term (5 days or less) to treat moderate to severe pain. Dosage should be adjusted for patients sixty-five (65) years or older, for patients under 110 lbs. of body weight, and for patients with moderately elevated serum creatinine.

her to take up to 7.4 gm per day of acetaminophen, for a period of seventy-three (73) days.

(g) Between on or about February 11, 2014, and on or about March 1, 2014, Respondent prescribed doses of Hydrocodone/APAP to patient B.B. sufficient for her to take up to 8.1 gm per day of acetaminophen, for a period of eighteen (18) days.

(h) The charts documented that Respondent prescribed Hydrocodone/APAP in variable strengths including, 325 MG-10 MG, 500 MG-10 MG, and 750 MG-10 MG. The rationale for prescribing variable strengths to a patient over seventy (70) years old, which resulted in significant dose variation of hydrocodone-acetaminophen, was not documented in patient B.B.'s chart.

(i) Based upon a review of the chart notes for these visits, there is no documentation that any lab work ever confirmed that patient B.B. had been taking the controlled pain medications that Respondent was routinely prescribing to her on a monthly basis.

(j) On or about October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient B.B. Prior to her subject interview, Respondent turned over patient B.B.'s medical records and certified, in writing, that the records she had submitted were the complete records for patient B.B. However, during Respondent's subject interview it became apparent that a substantial amount of information was missing from patient B.B.'s records, at which point Respondent represented to the Medical Board that a "second volume" of records existed and was located in storage. In terms of the amount of missing information, approximately fifty-five percent (55%) of the prescriptions for controlled substances issued by Respondent to patient B.B. were not documented in the medical records previously submitted to the Medical Board; which, it bears repeating, had been previously certified as "complete" by Respondent.

Significantly, at the time of filing of this First Amended Accusation, Respondent has yet to provide a copy of the alleged "second volume" of medical records to the Medical Board for its review despite an agreement made at the subject interview to turn them over.

(k) According to the CURES report for patient B.B. and her medication list in the medical record, the prescriptions for opioid medications issued by Respondent have been summarized in the table below.

| Patient Name | Date Filled[26] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.B. | 08-24-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| B.B. | 12-13-2011 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| B.B. | 02-21-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| B.B. | 07-11-2012 | Hydrocodone/APAP | TAB | 500 MG-10 MG | 240 | III |
| B.B. | 02-11-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 02-26-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 04-03-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 04-27-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 06-12-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 360 | III |
| B.B. | 07-10-2013 | Oxycodone HCL | TAB | 325 MG-5 MG | 60 | III |
| B.B. | 09-26-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 11-11-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 12-06-2013 | Hydrocodone/APAP | TAB | 750 MG-10 MG | 120 | III |
| B.B. | 02-11-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| B.B. | 04-12-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 120 | III |
| B.B. | 05-22-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| B.B. | 07-13-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| B.B. | 07-13-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| B.B. | 09-24-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |

[26] Patient B.B. filled her prescriptions on or about these dates.

| Patient Name | Date Filled[26] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| B.B. | 09-24-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | III |
| B.B. | 11-29-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | II |
| B.B. | 11-29-2014 | Hydrocodone/APAP | TAB | 325 MG-10 MG | 240 | II |

24. Respondent committed gross negligence in her care and treatment of patient B.B. including, but not limited to, the following:

(a) Respondent excessively prescribed, furnished, dispensed, and/or administered opioids to patient B.B.;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient B.B.;

(c) Respondent excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient B.B. between on or about April 27, 2013, and on or about July 9, 2013;

(d) Respondent excessively prescribed, furnished, dispensed, and/or administered acetaminophen to patient B.B. between on or about February 11, 2014, and on or about May 21, 2014;

(e) Respondent improperly issued prescriptions for multiple strengths of Hydrocodone/APAP at the same time and to the same patient;

(f) Respondent failed to obtain and document informed consent from patient B.B. prior to beginning treatment with opioids;

(g) At the office visit on or about September 15, 2011, Respondent failed to document an adequate physical examination, failed to document a thorough history, and failed to document a treatment plan for patient B.B.'s ulcer;

(h) At the office visit on or about October 25, 2012, Respondent failed to obtain and document informed consent from patient B.B. prior to administering a shot of Toradol;

(i) Respondent improperly issued prescriptions for controlled substances that exceeded a thirty (30) day supply; and

(j) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient B.B. The records are either missing, incomplete, lack adequate detail, and/or failed to provide Respondent's clinical rationale for the amounts and dosages of controlled medications that she had prescribed to patient B.B. The records failed to document her clinical judgment behind prescribing acetaminophen-containing medications at the dosage levels that she had prescribed to a patient over seventy (70) years old. The records also failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids. The records also failed to adequately document prescription information involving the timing, dosages, quantity, and issuance of controlled medications prescribed to patient B.B. The records also failed to document bases for any diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

25. **Patient R.H.**

(a) On or about November 12, 2013, patient R.H., a then-53-year-old male, was first seen by Respondent at her office. The chart note indicated that patient R.H. was establishing care with Respondent and a scant history of his medical history was recorded. The health history form indicated "foot infection" in 2013. Patient R.H. had multiple inter-related medical conditions including, uncontrolled Type 2 Diabetes Mellitus,[27] chronic osteomyelitis of the foot, chronic diabetic

[27] Type 2 Diabetes Mellitus is a long term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin. Complications include heart and blood vessel disease, neuropathy, nephropathy, eye damage, foot damage, hearing impairment, skin conditions, and Alzheimer's disease.

ulcers of the foot, history of amputation of toes, Charcot foot,[28] hypertension, hyperlipidemia, intravenous use of methamphetamine, peripheral neuropathy, and chronic pain.

(b) During the period of November 12, 2013, to December 17, 2014, Respondent charted seven (7) visits with patient R.H. As best as can be discerned from the handwritten chart notes, the visits took place on or about November 12, November 26, 2013; January 22, February 5, March 5, November 25, and December 17, 2014. The chart notes for these visits include inadequately documented prescriptions for opioids. The notes are missing the exact dose, quantity, and instructions for prescriptions issued for controlled pain medications. The chart notes failed to document a detailed history of patient R.H.'s pain; failed to document a detailed physical examination; failed to document how and to what extent the pain interfered with his function; and failed to adequately document a recognized indication for the use of opioids. In general, the chart notes are frequently either incomplete, illegible, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe controlled medications to patient R.H. for his chronic pain. Significantly, based upon a review of the chart notes for these visits, Respondent also failed to obtain and document informed consent prior to beginning treatment with controlled pain medications with patient R.H.

(c) A chart note dated November 26, 2013, documented history as "53 yo. L foot. DM. Meds. LBP c neuropathy." Under examination, "Extrem" was circled and the charted notation was "foot [illegible]." Respondent's diagnosis was "Non healing wound s/p amp ... DM." The plan included increasing Glucotrol and Oxycodone prescriptions, but, other than charting prescription information, no other information and/or discussion was documented regarding

[28] Charcot foot is a deformity that results from nerve damage (neuropathy) in the foot or ankle. It is a serious condition that can lead to severe deformity, disability and even amputation.

management of patient R.H.'s Type 2 Diabetes Mellitus. Respondent failed to document a number of areas critical to the management of this condition including, but not limited to, documentation of a diabetic foot exam; whether or not the patient measured his own blood or urine glucose; whether he had suffered symptomatic hyperglycemic or hypoglycemic episodes was not documented; cessation of tobacco; and no documentation of evidence of peripheral vascular insufficiency.

(d) A handwritten note in the record, dated on or about January 14, 2014, documented that somebody at Respondent's clinic had spoken with patient R.H. and had advised him to "go to urgent care on Main St." There is no other information in the note as to the patient's condition or the reason for the advisal to go to urgent care.

(e) A chart note dated February 5, 2014, documented that patient R.H. had been seen for a "DM check" and "medication refills." The note documented the patient's foot ulcers and that he had been advised to "self-monitor DM." A referral was also noted for diabetic care and controlled prescriptions were refilled. However, no other information and/or discussion was charted regarding the management of patient R.H.'s uncontrolled Type 2 Diabetes Mellitus, or for the previous month's documented advisal about urgent care.

(f) On or about February 18, 2014, approximately three (3) months after beginning treatment with addictive pain medications, patient R.H. signed a "Patient Contract for Using Opioid Pain Medication in Chronic Pain." Important stipulations of this contract included, that patient R.H. agreed his opioid medication would be prescribed by only one (1) doctor and that he would fill his prescriptions at only one (1) pharmacy. After signing the contract, Patient R.H. violated this stipulation and filled his controlled prescriptions at seven (7) different pharmacies, and filled prescriptions issued by five (5) different medical providers including Respondent. There is no documentation in his record cautioning against the use of multiple pharmacies and prescribers.

(g) The final charted visits are dated March 5, November 25, and December 17, 2014. At these visits, patient R.H. was seen for medication refills and, consistent with previous charted notes for this patient, the history recorded was scant and no other information and/or discussion was charted regarding the management of his uncontrolled Type 2 Diabetes Mellitus. In fact, at the November 25 visit, Respondent refilled controlled prescriptions without documenting the name, dosage, and quantity of medications in the note.

(h) On October 5, 2016, Respondent was interviewed at the California Medical Board's San Diego District Office regarding the care and treatment she had provided to patient R.H. During the subject interview, Respondent suggested that it was patient R.H.'s ultimate responsibility to determine whether he needed insulin and how to take it, as she explained:

> "I knew that he was a diabetic and that he couldn't afford the insulin. ...Well, I've only seen [patient R.H.] two times, and he's personally responsible. You don't need a prescription for insulin ... you can ... buy insulin out of prescription. You don't need a doctor. ... but if [patient R.H.] was told and he could afford it, then he could get it himself."

(i) According to the CURES report for patient R.H. and his medication list in the medical record, the prescriptions for opioid medications issued by Respondent have been summarized in the table below.

| Patient Name | Date Filled[29] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.H. | 11-12-2013 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 11-29-2013 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 12-20-2013 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 01-22-2014 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 02-06-2014 | Oxycodone HCL | TAB | 30 MG | 180 | II |

[29] Patient R.H. filled his prescriptions on or about these dates.

| Patient Name | Date Filled[29] | Controlled Drug | Drug Form | Strength | Quantity | Schedule |
|---|---|---|---|---|---|---|
| R.H. | 02-19-2014 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 03-05-2014 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| R.H. | 03-26-2014 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 04-10-2014 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| R.H. | 05-01-2014 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| R.H. | 06-10-2014 | Oxycodone HCL | TAB | 30 MG | 90 | II |
| R.H. | 06-26-2014 | Oxycodone HCL | TAB | 30 MG | 180 | II |
| R.H. | 11-25-2014 | Oxycodone HCL | TAB | 30 MG | 240 | II |
| R.H. | 12-17-2014 | Oxycodone HCL | TAB | 30 MG | 80 | II |
| R.H. | 12-23-2014 | Oxycodone HCL | TAB | 30 MG | 240 | II |
| R.H. | 01-22-2015 | Oxycodone HCL | TAB | 30 MG | 90 | II |

26. Respondent committed gross negligence in her care and treatment of patient R.H. including, but not limited to, the following:

(a) Respondent repeatedly failed to adequately assess diabetic disease markers, including, but not limited to, hemoglobin A1C, serum creatinine, urine microalbumin/creatinine ratio, lipid profile, blood glucose level trends, diabetic foot examination, and diabetic retinal examination;

(b) Respondent repeatedly failed to document a specific assessment and plan for patient R.H.'s Type 2 Diabetes Mellitus;

(c) Respondent repeatedly failed to document a specific assessment and plan for patient R.H.'s Charcot foot;

(d) Respondent failed to maintain an accurate medication list that included the specific doses and frequencies of administrations for all medications that she had prescribed to patient R.H., including metformin, glipizide, and oxycodone;

(e) Respondent excessively prescribed, furnished, dispensed, and/or administered opioids to patient R.H.;

(f) Respondent failed to obtain and document informed consent from patient R.H. prior to beginning treatment with opioids; and

(g) Respondent failed to maintain adequate and accurate records in regard to her care and treatment of patient R.H. The records lack clear documentation of history relevant to Type 2 Diabetes Mellitus; failed to adequately document prescription information involving the timing, dosages, quantity, and issuance of controlled medications prescribed to patient R.H.; failed to document a comprehensive medical history and physical examination prior to initiating treatment of chronic pain with opioids; failed to document bases for any diagnoses and rationales for any medical decisions, including changes in medications and/or responses to medications, which were not adequately documented; and there were no clear treatment plans documented in the records.

27. **Patient M.W.**

(a) On or about October 21, 2013, Respondent had her first visit with patient M.W., a then-38-year-old female. Patient M.W. suffered from low back pain and irritable bowel syndrome. Respondent documented "med refill on all medications" in the chart. Respondent performed a cursory examination of patient M.W. and documented only scant notations for diagnoses and plan in the chart. Respondent then refilled prescriptions for controlled medications including, Norco and Ambien.[30]

[30] Ambien is a brand name for zolpidem tartrate, which is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. As a controlled substance, Ambien is a sedative used for the short-term treatment of insomnia, typically two to three (2 to 3) weeks. If treatment of insomnia with Ambien extends beyond this initial period, regular follow-up by the treating physician is recommended to assess for efficacy, possible side-effects and harms, as well as to evaluate other treatment approaches including other medication classes. Ambien has central nervous system depressant effects and its use can potentially worsen symptoms of depression and suicidal thoughts in patients suffering from depression. The use of Ambien is associated with increased incidence of completed suicide. It should be prescribed with caution in patients suspected of having depression and in the lowest effective dose.

(b) Between in or around October, 2013, and in or around May, 2016, Respondent saw patient M.W. on an intermittent basis but still prescribed controlled pain medications to this patient, and without making any entries in the patient's chart notes on several occasions. During this period of time, the chart notes for the visits failed to document a comprehensive history of this patient's back pain; failed to document a detailed physical examination; failed to document how and to what extent the pain interfered with her function; failed to adequately document a recognized indication for the use of opioids; failed to document reason(s) for changing patient's drug prescription from Norco to Percocet; failed to document a request and/or plan for psychiatric co-management of this patient's care due to prescribing a high-risk drug combination of Norco and Ambien for more than two (2) years to a patient diagnosed with depression; failed to adequately document a comprehensive substance abuse history; and failed to obtain urine drug screening and/or document and address multiple signs of aberrant drug behavior by this patient including, multiple requests for early prescription re-fills and receiving prescriptions for controlled pain medication from other medical providers. In general, the chart notes are frequently either illegible, incomplete, lack adequate detail regarding physical examination and medical indication for prescribing controlled medications, fail to develop a rational treatment plan with verifiable benchmarks, and/or fail to provide a clear rationale for continuing to prescribe controlled medications to patient M.W. for her chronic pain.

28. Respondent committed gross negligence in her care and treatment of patient M.W. including, but not limited to, the following:

(a) Respondent failed to substantially comply with appropriate controlled substance prescribing practices.

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## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

29. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of patients A.M., B.Y., R.A., I.A., B.B., R.H., M.W., and K.J., as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient I.A.**

(d) Paragraphs 21 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.B.**

(e) Paragraphs 23 and 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.H.**

(f) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient M.W.**

(g) Paragraphs 27 and 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient K.J.**

(h) Between in or around 2011, and in or around 2015, Respondent and her clinical staff, whom she supervised, saw patient K.J. at Respondent's clinic. During this period of time, patient K.J. was seen at Respondent's clinic for a number of issues including, general wellness exams and weight loss. All of the progress notes from Respondent's clinic for this patient were handwritten; and the notes were often illegible, unclear, and/or missing signatures of the medical care provider who saw the patient.

(i) Respondent committed repeated negligent acts in her care and treatment of patient K.J., which included, but was not limited to, the following:

(1) Respondent failed to clearly and legibly document the care and treatment provided to this patient, failed to sign the progress notes, and/or failed to ensure that her clinical staff under her supervision were clearly documenting and legibly signing the progress notes for this patient.

**THIRD CAUSE FOR DISCIPLINE**

**(Incompetence)**

30. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in her care and treatment of patients A.M., B.Y., R.A., I.A., B.B., and R.H., as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient I.A.**

(d) Paragraphs 21 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.B.**

(e) Paragraphs 23 and 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.H.**

(f) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**FOURTH CAUSE FOR DISCIPLINE**

**(Furnishing Drugs to Addict)**

31. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 2241, of the Code, in that Respondent prescribed, dispensed, and/or administered dangerous drugs and/or controlled substances to patients A.M., B.Y., and R.A., whom she knew or reasonably believed was an addict and was using or would be using the dangerous drugs and/or controlled substances for a non-medical purpose, as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**FIFTH CAUSE FOR DISCIPLINE**

**(Prescribing Dangerous Drugs Without an Appropriate Prior Examination and/or Medical Indication)**

32. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in sections 2242 and 4022, of the Code, in that Respondent prescribed, dispensed, or furnished dangerous drugs without an appropriate prior examination and/or medical indication to patients A.M., B.Y., R.A., I.A., B.B., R.H., and M.W., as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient I.A.**

(d) Paragraphs 21 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.B.**

(e) Paragraphs 23 and 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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**Patient R.H.**

(f) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient M.W.**

(g) Paragraphs 27 and 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

## SIXTH CAUSE FOR DISCIPLINE

### (Repeated Acts of Clearly Excessive Prescribing)

33. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to patients A.M., B.Y., R.A., I.A., B.B., and R.H., as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient I.A.**

(d) Paragraphs 21 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.B.**

(e) Paragraphs 23 and 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.H.**

(f) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Medical Records)**

34. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with her care and treatment of patients A.M., B.Y., R.A., I.A., B.B., R.H., M.W., and K.J., as more particularly alleged hereinafter:

**Patient A.M.**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.Y.**

(b) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.A.**

(c) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient I.A.**

(d) Paragraphs 21 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient B.B.**

(e) Paragraphs 23 and 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient R.H.**

(f) Paragraphs 25 and 26, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient M.W.**

(g) Paragraphs 27 and 28, above, are hereby incorporated by reference and realleged as if fully set forth herein.

**Patient K.J.**

(h) Paragraph 29, subdivisions (h) and (i), above, are hereby incorporated by reference and realleged as if fully set forth herein.

## EIGHTH CAUSE FOR DISCIPLINE

### (Unprofessional Conduct)

35. Respondent has further subjected her Physician's and Surgeon's Certificate No. G76077 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 15 through 34, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's License No. G76077, issued to Respondent Laura Ann Williams, M.D.;

2. Revoking, suspending or denying approval of Respondent Laura Ann Williams, M.D.'s, authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Laura Ann Williams, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 28, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

SD2017704301 / Doc.No.81984697